HIPPA Acknowledgement Form

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that Kittley Family Medicine provided me with a written copy of his/her Notice of Privacy Practices to review and understand.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature **Date**

_____ _____

Personal Representative Signature (if applicable) **Relationship to Patient**